NEW ROLES FOR PERSONNEL IN HOSPITALS: PHYSICIAN EXTENDERS*

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IT is always fun to be on a program with Dr. Luther Christman, because we do not always agree. Medical practice does not require an advanced training in science. We have a lot of bright young interns from all kinds of schools, who come to learn the science of practice and the application of science to patient care. I point out that maybe it would have been just as well if they had stayed at home. I could, within a couple of days, present all the science useful in medical practice.

Now you must remember that there is a lot of knowledge in the world for many purposes, but there is so much non-knowledge when it comes to the care of patients that the proportion of non-knowledge used on any day is at least 90% of what the doctor does. Now you must appreciate that it takes some knowledge of science to make a radio. At least it takes some, if there has been no radio made before. But one does not have to be a scientist to operate the radio. So the president of RCA runs his radio and I run mine, and we do it equally well. When the thing breaks down, neither of us knows what to do.

So you must differentiate between investment in science, which is related to the creation of things unknown—be it knowledge or machines or various kinds of things—and application of science which in itself most of the time is relatively simple.

Along the way I have had experiences that were helpful to me in getting to where I stand now. I happened to be a professor of medicine at Emory University during World War II. We had a long negotiation about how many interns we were going to have, and it was decided that the number of interns I could have was equal to that of a date 15 years earlier. Well, at

*Presented in a panel, New Roles for Personnel in Hospitals: Nurses and Physician Extenders, as part of the 1978 Annual Health Conference of the New York Academy of Medicine, *The Hospital Reconsidered: A New Perspective*, held May 1 and 2, 1978.

that time there were no interns, so I came up with a figure very close to zero. But I still had a lot of patients to take care of, so I calmly conscripted the third- and fourth-year students. I just said, "We've got a lot of folks to take care of: it's going to take most of the day and a fair part of the night, and I'm not asking you whether you want to do it; I'm just merely pointing out that these are the requirements and, if you stay here, this is what you're going to do and, if you don't, the Army would love to have you in another capacity."

I think the astonishing thing about it was that they gave superb medical care. You could not tell after a while the difference between the third-year student, who had never been through the last two years of medical school, and an intern. You learn by doing, and the things which a doctor does at any one moment are not terribly complex. There is a tremendous number of them so there is a lot of experience to be had. But none of the particular procedures are terribly hard.

It is only when you go to cut new paths that you require a different kind of background and a different kind of education. But I did learn that they did not need to go to medical school to learn to practice medicine. That turned out to be perfectly obvious.

My next experience came with a group of nurses at Duke University in the early 1960s. Thelma Ingles wished to train nurses to be able to give a larger quantity and variety of services. So she set up a master's degree program and I agreed to interact and teach the nurses anything I knew that they wished to learn. They were very intelligent and they learned quickly, and at the end of a year we had produced a superb product, one capable of doing more than any nurse I had ever met.

Well, we fell on evil times. The nursing hierarchy would not credit the master's program. Miss Ingles went off to The Rockefeller Foundation, having taught me again that people from varied backgrounds can apply knowledge very effectively at the level of patient care.

When the war ended I had more time for reflection. It became obvious that the nurses had not changed much during the period, when major changes had occurred in medical practice. I am not being critical of why they had not changed: I am merely making the statement. So the ceiling for the nurse in 1960 was approximately what it had been in 1938. And beneath that ceiling had grown a whole variety of plans: we had practical nurses; we had two-year nurses; we had diploma nurses; and we had degree nurses.

And there was not much room under the ceiling. And, since bright people will learn, at the end of two or three years there was not very much difference in the performance in all those categories of nurses. Now, during that period of time, there had been a tremendous jump in the activities with doctors, so that now there was a very large gap between what the registered nurse did, what the degree nurse did, and what the doctor did. But nobody was moving into that gap.

There were technical people who took x rays or looked at Pap smears, but nobody was moving into that gap in the area in which you actually touched people—putting hands on people—which had been the traditional role of the doctor and the nurse. And, therefore, around 1963 we elected to move into that gap with a product we called "physician's assistant" and which we later changed to "physician's associate."

I had some very strong prejudices at that time and I guess it is fair to say they are still with me, but the physician's associates by and large are not included in my prejudices.

First, I am not very degree-conscious. I have always been performance-conscious. If one does something, I can appreciate it. If one gives me a degree, I do not really know what to do with it. And therefore I was interested in starting out to train people on a high-school basis.

The second thing I was interested in was the generalist. I was interested in people who could do a whole series of things. Because, when you take care of people, if you become too specialized, you tend to sit around; that special function is not needed and, you know, you smoke cigarettes or drink Coca Colas or whatever. But if you are a generalist, in the medical world there is always something to do.

So I was really interested in people who were not afraid to say what the simple elements of a diet were; were not afraid to do simple portions of physiotherapy; were not afraid of taking off a bandage and putting it on; were not afraid of going into the home to see whether the older person there had food in the refrigerator.

I did not see any reason people could not sew up wounds, fix simple fractures, put needles in a variety of places, or counsel individuals. You know, I wanted people just to do things. It seemed to me that the more general you made the base, the more production you could get out of the individual person.

I felt, and I still have some prejudice in that direction, that if we want to select this product, go to all the trouble to train it, eventually employ it,

this could best operate as an arm of the physician and not as an arm of either the hospital or anybody else. And, indeed, this is the way my own practice goes, and my physician's associate is an extension of myself. I interact with a nursing service, the hospital administration, the nursing home administration, or what not. The physician's associate belongs to the medical side of this organization as contrasted with the nursing side.

Now the thing has gone very well, as you know. We suggested in 1960 that it would be better to have a managed system of care and not quite as many entrepreneurs. The establishment decided to have a tremendous increase in the entrepreneurial output and therefore we are going to have doctors running out of our ears. The question is, if you have that many entrepreneurs, how do you really manage anything? The answer may be that it just cannot be done. We made a mistake in 1960 and we have to live through it.

In all the areas in which I have seen them operate, the physician's associates have done extraordinarily well. My physician's associate has been with me 2½ years and I would say she can handle almost anything; nearly anything that I know, she knows. After all, she is bright and every day she learns something.

I am at a disadvantage in a formal educational establishment. I have been teaching in medical schools since 1932, and I have still to give my first assignment. If the student stops reading, it is his responsibility, not mine. And it is amazing, if you do not have a ceiling, how many people will stick their heads higher than you ever thought they would. So I have never told anybody to stop learning.

I have always operated with a sort of open system. I appreciate that there are licensing boards, I appreciate that there are a lot of jurisdictional things, and I appreciate that there can be a lot of fears in a variety of people. My experience is that when you do not want to do something, you get very fearful. If you do want to do something, you are not nearly as fearful.

So my advice to the physician's associates has always been to go where you are needed. Find the place where something is squeaking, and become the oil to eliminate the squeak. When you go where you are not needed, and are pushing into places where people do not want you—where the shoe is not squeaking—you are much more liable to have people say: "I don't like you. It's pretty crowded here; I wish you'd get out."

So it does make sense for the physician's associates to move into areas

where they actually are needed. And many of them have. Now, just one word about the relation between the physician's associates and nurse-practitioners. The greatest service I ever did for nursing was to start the physician's associate program. A number of nurses began to appreciate the fact that somebody else was moving into an area which had been open a long time and which they had neglected to move into.

Therefore, I would say that the nurse-practitioner in general is kind of a child of the physician's associate and it looks like a pretty healthy child. I have stayed with the PA program as a better prototype than the nurse-practitioner for one reason: I do not believe that people have to have ceilings put on them, I think that if you go for your training to the people who know the most, then you will have the highest ceiling. Over the years I do not know of any nurse-practitioner group that can field the faculty that the Duke physician's associate group can field. And unless that faculty becomes ceiling-minded, then the Duke-trained physician's associate will continue to be, in terms of training, more capable than the average person trained around the country.

Miss Ingles and I played a role by advising the Johnson Foundation of the limitation in the ceiling of nurse practitioners unless they could develop nursing faculties of greater clinical competence than they had in the past. And Johnson Foundation last year did announce a series of advanced scholarships to nursing faculties, to develop increased clinical competence.

All I can say is that now there is a considerable output of people moving into the laying on of hands, between what the nurse traditionally did up to a few years ago and what the doctor has done over these many years; and it is going to be very interesting to see how these things fall out and what roles they finally play.

I have to say regretfully that Duke University is moving more and more toward selecting people who pass the examination easily. All faculties have always selected students with one criterion—as far as I know, only one criterion—the student who can pass the work easily and cause the faculty little trouble. Our PA course has become more formalized. It now offers a degree although it is not a requirement; we are having pharmacology and physiology taught by people who are not really concerned with giving care to patients, but who want students who will require the least time.

I think this has been an unfortunate development, but I can easily see the reason why administratively those decisions have been made.